§447.256 Procedures for CMS action on assurances and State plan amendments.

(a) *Criteria for approval.* (1) CMS approval action on State plans and State plan amendments, is taken in accordance with subpart B of part 430 of this chapter and sections 1116, 1902(b) and 1915(f) of the Act.

(2) In the case of State plan and plan amendment changes in payment methods and standards, CMS bases its approval on the acceptability of the Medicaid agency's assurances that the requirements of §447.253 have been met, and the State's compliance with the other requirements of this subpart.

(b) *Time limit.* CMS will send a notice to the agency of its determination as to whether the assurances regarding a State plan amendment are acceptable within 90 days of the date CMS receives the assurances described in §447.253, and the related information described in §447.255 of this subpart. If CMS does not send a notice to the agency of its determination within this time limit and the provisions in paragraph (a) of this section are met, the assurances and/or the State plan amendment will be deemed accepted and approved.

(c) *Effective date.* A State plan amendment that is approved will become effective not earlier than the first day of the calendar quarter in which an approvable amendment is submitted in accordance with §§430.20 of this chapter and 447.253.

[48 FR 56058, Dec. 19, 1983, as amended at 52 FR 28147, July 28, 1987]

FEDERAL FINANCIAL PARTICIPATION

§447.257 FFP: Conditions relating to institutional reimbursement.

FFP is not available for a State's expenditures for hospital inpatient or long-term care facility services that are in excess of the amounts allowable under this subpart.

[52 FR 28147, July 28, 1987]

UPPER LIMITS

§447.271 Upper limits based on customary charges.

(a) Except as provided in paragraph (b) of this section, the agency may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.

(b) The agency may pay a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider charges were equal to or greater than its costs.

[75 FR 73975, Nov. 30, 2010]

§447.272 Inpatient services: Application of upper payment limits.

(a) *Scope.* This section applies to rates set by the agency to pay for inpatient services furnished by hospitals, NFs, and ICFs/IID within one of the following categories:

(1) State government-owned or operated facilities (that is, all facilities that are either owned or operated by the State).

(2) Non-State government-owned or operated facilities (that is, all government facilities that are neither owned nor operated by the State).

(3) Privately-owned and operated facilities.

(b) *General rules.* (1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter.

(2) Except as provided for in paragraph (c) of this section, aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (a) of this section may not exceed the upper payment limit described in paragraph (b)(1) of this section.

(c) *Exceptions*—(1) *Indian Health Services and tribal facilities.* The limitation in paragraph (b) of this section does not apply to Indian Health Services facilities and tribal facilities that are funded through the Indian Self-Determination and Education Assistance Act (Pub. L. 93–638).

(2) *Disproportionate share hospitals.* The limitation in paragraph (b) of this section does not apply to payment adjustments made under section 1923 of the Act that are made under a State plan to hospitals found to serve a disproportionate number of low-income patients with special needs as provided in section 1902(a)(13)(A)(iv) of the Act. Disproportionate share hospital (DSH)

payments are subject to the following limits:

(i) The aggregate DSH limit using the Federal share of the DSH limit under section 1923(f) of the Act.

(ii) The hospital-specific DSH limit in section 1923(g) of the Act.

(iii) The aggregate DSH limit for institutions for mental disease (IMDs) under section 1923(h) of the Act.

(d) *Compliance dates.* Except as permitted under paragraph (e) of this section, a State must comply with the upper payment limit described in paragraph (b) of this section by one of the following dates:

(1) For non-State government owned or operated hospitals,—March 19, 2002.

(2) For all other facilities—March 13, 2001.

[66 FR 3175, Jan. 12, 2001, as amended at 66 FR 46399, Sept. 5, 2001; 67 FR 2610, Jan. 18, 2002; 72 FR 29834, May 29, 2007; 75 FR 73975, Nov. 30, 2010; 77 FR 31512, May 29, 2012]

SWING-BED HOSPITALS

§ 447.280 Hospital providers of NF services (swing-bed hospitals).

(a) *General rule.* If the State plan provides for NF services furnished by a swing-bed hospital, as specified in §§ 440.40(a) and 440.150(f) of this chapter, the methods and standards used to determine payment rates for routine NF services must—

(1) Provide for payment at the average rate per patient day paid to NFs, as applicable, for routine services furnished during the previous calendar year; or

(2) Meet the State plan and payment requirements described in this subpart, as applicable.

(b) *Application of the rule.* The payment methodology used by a State to set payment rates for routine NF services must apply to all swing-bed hospitals in the State.

[59 FR 56237, Nov. 10, 1994]

Subpart D [Reserved]

Subpart E—Payment Adjustments for Hospitals That Serve a Disproportionate Number of Low-Income Patients

SOURCE: 57 FR 55143, Nov. 24, 1992, unless otherwise noted.

§ 447.294 Medicaid disproportionate share hospital (DSH) allotment reductions for Federal fiscal year 2014 and Federal fiscal year 2015.

(a) *Basis and purpose.* This section sets forth the DSH health reform methodology (DHRM) for calculating State-specific annual DSH allotment reductions from Federal fiscal year 2014 and Federal fiscal year 2015 as required under section 1923(f) of the Act.

(b) *Definitions.* For purposes of this section—

Aggregate DSH allotment reductions mean the amounts identified in section 1923(f)(7)(A)(ii) of the Act.

Budget neutrality factor (BNF) is a factor incorporated in the DHRM that takes into account the extent to which the DSH allotment for a State was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009.

DSH payment means the amount reported in accordance with § 447.299(c)(17).

Effective DSH allotment means the amount of DSH allotment determined by subtracting the State-specific DSH allotment reduction from a State's unreduced DSH allotment.

High level of uncompensated care factor (HUF) is a factor incorporated in the DHRM that results in larger percentage DSH allotment reduction for States that do not target DSH payments on hospitals with high levels of uncompensated care.

High Medicaid volume hospital means a disproportionate share hospital that has an MIUR at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the State.

High uncompensated care hospital means a hospital that exceeds the mean ratio of uncompensated care costs to total Medicaid and uninsured